

Internal Audit Department

O R A N G E C O U N T Y
 6th Largest County in the USA

FINAL CLOSE-OUT FIRST FOLLOW-UP INTERNAL CONTROL AUDIT: HEALTH CARE AGENCY MEDICAL BILLING PROCESS

AS OF JUNE 15, 2013

Our First Follow-Up Audit found that the Health Care Agency fully implemented all four (4) recommendations from our original audit report dated December 13, 2012.

During the original audit period, annual medical billings totaled \$73 million for services provided under HCA's Behavioral Health, Public Health, and Medical and Institutional Health Services programs.

AUDIT NO: 1227-E
 ORIGINAL AUDIT NO. 1018

REPORT DATE: JUNE 28, 2013

Director: Dr. Peter Hughes, MBA, CPA, CIA
 Senior Audit Manager: Michael Goodwin, CPA, CIA

RISK BASED AUDITING

GAO & IIA Peer Review Compliant – 2001, 2004, 2007, 2010



American Institute of Certified Public Accountants Award to Dr. Peter Hughes as 2010 Outstanding CPA of the Year for Local Government

GRC (Government, Risk & Compliance) Group 2010 Award to IAD as MVP in Risk Management



2009 Association of Certified Fraud Examiners' Hubbard Award to Dr. Peter Hughes for the Most Outstanding Article of the Year – Ethics Pays



2008 Association of Local Government Auditors' Bronze Website Award



2005 Institute of Internal Auditors' Award to IAD for Recognition of Commitment to Professional Excellence, Quality, and Outreach

 Internal Audit Department

GAO & IIA Peer Review Compliant - 2001, 2004, 2007, 2010

Providing Facts and Perspectives Countywide

RISK BASED AUDITING

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OC Fraud Hotline (714) 834-3608

Letter from Dr. Peter Hughes, CPA

Transmittal Letter



Audit No. 1227-E June 28, 2013

TO: Mark Refowitz, Director
Health Care Agency

FROM: Dr. Peter Hughes, CPA, Director
Internal Audit Department

SUBJECT: **First and Final Close-Out** Follow-Up Audit:
Health Care Agency Medical Billing Process,
Original Audit No.1018, Issued December 13, 2012

We have completed a First Follow-Up Audit of the Health Care Agency Medical Billing Process. Our audit was limited to reviewing, as of June 15, 2013, actions taken to implement the **four (4) recommendations** from our original audit. We conducted this First Follow-Up Audit in accordance with the *FY 12-13 Audit Plan and Risk Assessment* approved by the Audit Oversight Committee and Board of Supervisors (BOS).

The results of our First Follow-Up Audit are discussed in the **OC Internal Auditor's Report** following this transmittal letter. Because satisfactory corrective action has been taken for the four (4) recommendations, **this report represents the final close-out of the original audit.**

Each month I submit an **Audit Status Report** to the BOS where I detail any material and significant audit findings released in reports during the prior month and the implementation status of audit recommendations as disclosed by our Follow-Up Audits. Accordingly, the results of this audit will be included in a future status report to the BOS.

Other recipients of this report are listed on the **OC Internal Auditor's Report** on page 5.

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Audit No. 1227-E*

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OC Internal Auditor's Report



Audit No. 1227-E

June 28, 2013

TO: Mark Refowitz, Director
Health Care Agency

FROM: Dr. Peter Hughes, CPA, Director
Internal Audit Department

SUBJECT: **First and Final Close-Out** Follow-Up Audit:
Health Care Agency Medical Billing Process,
Original Audit No. 1018, Issued December 13, 2012

Scope of Review

We have completed a First Follow-Up Audit of the Health Care Agency (HCA) Medical Billing Process. Our audit was limited to reviewing actions taken, as of June 15, 2013, to implement the **four (4) recommendations** from our original audit report.

Background

We conducted an Internal Control Audit of the HCA Medical Billing Process, which included an evaluation and testing of internal controls, compliance with HCA's and County policies, and evaluating process efficiencies and effectiveness. We audited the adequacy of manual and IT system controls over HCA's Medical Billing Process. During FY 10-11, HCA's **medical billings totaled over \$73 million** for Behavioral Health, Public Health, and Medical and Institutional Health Services provided through County/HCA operated clinics and by contract providers.

The original audit identified **four (4) Control Findings** where HCA should continue efforts to complete business continuity planning documents; consider reducing the extent of its pre-billing and post-payment reviews; and evaluate generating management reports from the Integrated Records Information System (IRIS) to monitor the effectiveness of the medical billing process.

Results

Our First Follow-Up Audit found that HCA **implemented all four (4) recommendations**. **As such, this report represents the final close-out of the original audit.** Based on our First Follow-Up Audit, the following is the implementation status of the four (4) recommendations:

1. Need to Complete Business Continuity Planning Documents

HCA continue to participate with the Countywide Business Continuity planning project and make it a priority to complete and submit the Business Continuity Fundamental Plan Components documents (Phase One).

Current Status: **Implemented.** The original audit found that HCA had completed and submitted to CEO/IT about 9% of the documents for Business Continuity Fundamental Plan Components. HCA made the completion of these documents a priority based upon our recommendation. On May 21, 2013, the Board of Supervisors (BOS) directed the CEO to provide a status report to the Board on agencies/department's progress toward completion of Business Continuity Plans. At that time, HCA was at 67% completion. Subsequent to the BOS directive, CEO/Information Technology and the County Chief Information Officer established a target date of August 30, 2013 to have all agencies/departments complete their Business Continuity Plans. As a result of the BOS directive and CEO/IT request, business continuity planning became a Countywide priority to complete.



Our First Follow-Up Audit found HCA immediately took steps to make the Business Continuity Plan a priority and established a work group to complete the plan. Resources were provided to this effort and staff attended the Business Continuity workshop presented by CEO/IT. HCA has recurring Business Continuity meetings twice a week to review the plans, and resources will be added if needed to meet the August 30th deadline.

As of this report date, HCA has **completed and submitted 97%** of its Business Continuity Plan documents to CEO/IT. Because HCA identified the project as an agency priority, is satisfactory completing the required Business Continuity Plan documents, and will complete the project before the August 30th deadline, we consider this recommendation implemented.

2. **Pre-Billing and Post-Payment Reviews for Behavioral Health Services Claims**

HCA evaluate its pre-billing review process for Medi-Medi Claims and determine the need to continue the current process which requires both reviews at MBU and QIPC. In addition, HCA should evaluate its pre-billing and post payment review process for Behavioral Health Services Medicare claims with consideration of frequency and sample sizes of the reviews given they are below the industry standard in the number of errors identified.

Current Status: Implemented. The original audit found that HCA continued to perform extensive pre-billing and post-payment reviews on Medi-Cal and Medicare claims since the Integrity Agreement between HCA and the Office of the Inspector General ended in December 2010. In response to the audit, HCA analyzed the role of the Medical Billing Unit (MBU) and Quality Improvement and Program Compliance (QIPC) in the billing review process. Several key changes were made to the review process during the course of the original audit and are still in effect.



The **pre-billing review** for combined Medi-Cal and Medicare (Medi-Medi) claims was modified to include only the MBU Coder review, and no longer includes a QIPC review. In our First Follow-Up Audit, we observed documentation showing the weekly MBU Coder reviews for services performed at the HCA clinics. HCA continues to review 100% of Medicare claims due to the conservative approach of the agency. QIPC no longer performs pre-billing reviews on Medi-Medi and Medi-Cal claims.

The **post-payment review** for Medicare claims for Behavioral Health Services was also analyzed and was adjusted to reflect the low error rate. However, HCA reported there was a significant change in medical billing codes for Medicare that went into effect January 2013. Because of the change in medical billing codes, HCA continues to perform 100% post-payment reviews on claims for dates of service January 1, 2013 and after. For dates of service prior to January 1, 2013, a 20% sample size is used. HCA's policy for post-payment reviews of Medicare claims is if the error rate in the reviews is consistently at 2% or less, the sample size will be modified to 20%. If the error rate increases, the sample size for the program is adjusted. If the error rate remains at or below 2% for six months, the sample size will be decreased to 10%. We observed spreadsheets that showed the changes in sample sizes for Medicare post-payment reviews, and noted the refunds or corrections identified in the reviews were minimal and ranged from \$14 to \$336.

QIPC now completes post-payment reviews (audits) on Medi-Medi and Medi-Cal claims on a sample basis. We observed QIPC policies and procedures, sampling methodologies, and audit tracking reports showing the completion of the post-payment audits. QIPC audits both County-operated and contractor-operated clinics. QIPC follows-up on all items recommended for recoupment. We observed audit tracking spreadsheets that showed post-payment audits conducted on May 1, 2013, for March 2013 transactions and noted the corrections and recoupment amounts identified in the audits were minimal.

Because HCA took satisfactory corrective action to evaluate its pre-billing and post-payment review processes, including establishing procedures to increase/decrease sample sizes based on acceptable error rates, we consider this recommendation implemented.

3. **Post-Payment Reviews for Public Health Services Claims**

HCA continue to evaluate the current post-payment review process for PHS claims to determine if revision is needed to limit the sample size at a reasonable amount to enhance effectiveness and efficiency of the post-payment reviews.

Current Status: **Implemented.** The original audit found that the quarterly post-payment reviews performed in the MBU for Family Pact Program (FPACT) claims under were behind schedule. FPACT is administered under Public Health Services (PHS). Since our original audit, HCA reviewed the post-payment review process for PHS claims and the sample size was reduced from 20% to 10% as of April 2011.

Our First Follow-Up Audit found that the MBU is current in performing the quarterly post-payment reviews of FPACT claims. The last review was completed on April 15, 2013 for the quarter January – March, 2013. The review for the quarter April – June 2013 was in process during our follow-up fieldwork. We also verified that the sample size was reduced to 10%. The exceptions noted in the reviews were minimal and consisted of small dollar amounts with error rates being 2% or less. HCA informed us that the sample size will remain in effect as long as the accuracy rate remains high. Post-payment review samples are now provided to the MBU Coder by an MBU IT Systems Technician. The MBU maintains a spreadsheet showing the results of the FPACT post-payment reviews.



Because HCA evaluated its post-payment review process for PHS claims, revised the sample size from 20% to 10%, allocated responsibility for providing samples, is current in the post-payment review process, and maintains a tracking spreadsheet to document the FPACT post-payment reviews, we consider this recommendation implemented.

4. Utilization of IRIS Management Reports

HCA determine the capability of IRIS for generating other management reports to assist management in monitoring the effectiveness of processes and controls for Behavioral Health Services provided and billed.

Current Status: **Implemented.** Our original audit noted that the Integrated Records Information System (IRIS) contains information on Behavioral Health Services provided and related billings, and that certain management reports can be generated from the system. However, the information was not always readily available to users and required additional resources to generate IRIS management reports.

HCA informed us that during our audit fieldwork, there was a significant national upgrade with Medi-Cal [based upon Short Doyle Medi-Cal (SD/MC) Phase 2] starting in January 2010 to the Electronic Data Interchange standard, which caused a complete re-design of the State's Medi-Cal system. For a period of about 18-24 months, Medi-Cal's adjudication system was in transition and was not completed and stable until mid-2012, after our audit fieldwork was completed. HCA was implementing SD/MC Phase 2 and resources were devoted to this major endeavor and were not readily available during the audit.

HCA informed us that IRIS reports are very dynamic in that the reporting criterion is dependent on the current state of billing and reporting requirements. Any changes made by the Medicare or Medi-Cal adjudication system usually require modifications to nearly every report. It is common for complex reports to be modified numerous times. Reports are continuously updated as the billing, coding and reporting processes evolve under HIPAA. IRIS has the capability to make queries when a user reports an issue or wants certain information reported from the system.

Our First Follow-Up found that IRIS generates about 40 Charge Audit/Units-of-Service reports and over 400 other reports for various uses. Spreadsheets are maintained showing the report/program name, report purpose and description, and last update/modification date. Several reports were noted that can assist management in monitoring the medical billing process. HCA also maintains a Medical Billing Data Warehouse outside of IRIS that is a repository of all adjudicated 835 files (claims) that were processed in IRIS and is used to generate numerous management reports on medical billing. One report called the *State of Charges Report* (SOCR) provides management with statistics on the number of claims submitted, paid, rejected or not accepted due to non-compliance or denials, and an aging of claims submitted. HCA Management also reported that they receive adequate reports from IRIS and the Data Warehouse to assist their oversight of the medical billing process.

Because HCA utilizes IRIS and the Data Warehouse to generate management reports for monitoring effectiveness of the medical billing process, has the capability to assist end users when issues arise, and management receives adequate reports to provide monitoring and oversight, we consider this recommendation implemented.

OC Internal Auditor's Report



We appreciate the assistance extended to us by the Health Care Agency and HCA Accounting Services staff during our Follow-Up Audit. If you have any questions, please contact me directly at 834-5475 or Michael Goodwin, Senior Audit Manager at 834-6066.

Distribution Pursuant to Audit Oversight Committee Procedure No. 1:

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